

The Changing Role Of The State Psychiatric Hospital

Eliminating state hospitals remains a goal despite the enduring importance of the services they provide.

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ABSTRACT: State hospitals were once the most prominent components of U.S. public mental health systems. But a major focus of mental health policy over the past fifty years has been to close these facilities. These efforts led to a 95 percent reduction in the country's state hospital population. However, more than 200 state hospitals remain open, serving a declining but challenging patient population. Using national and state-level data, this paper discusses the contemporary public mental hospital, the forces shaping its use, the challenges it faces, and its possible future role in the larger mental health system. [*Health Affairs* 28, no. 3 (2009): 676–684; 10.1377/hlthaff.28.3.676]

DURING THE FIRST HALF OF THE TWENTIETH CENTURY, state hospitals were the primary locus of care and treatment for people with mental illnesses and, often, for others without a discernable mental illness but in need of long-term care or support. Efforts to reduce the use of and ultimately close state hospitals occupied a central place on the U.S. mental health policy agenda for the second half of the twentieth century. However, state hospitals remain in operation, albeit fewer in number and with fewer patients.¹ The vision of a public mental health system without a state hospital has rarely been realized.² Prospects for achieving that goal are dimming; indeed, across the United States, the decline in the state hospital population has stalled and for the first time in more than fifty years has shown an uptick in some states. These facilities remain a fiscal burden, however; 2006 state hospital spending approached \$7.7 billion—nearly one-third of state mental health agency (SMHA) budgets. Several states plan to close or consolidate their hospitals, but others have recently built, are building, or plan to build new ones.³

To some observers of mental health policy, the persistence of state hospitals in the first decade of the twenty-first century might come as both a surprise and, perhaps, a disappointment. But this persistence argues that we look at these insti-

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tutions again, to discern where they fit in today's mental health system, whom they serve, and, most importantly, what their futures might be. This paper explores these questions.

State Hospitals In An Evolving Continuum Of Care

Two principles emerge from the history of state hospitals and their precursors, from colonial times through the mid-to-late twentieth century. The first is that state hospitals' roles today have been shaped by numerous local and national forces, some of recent origin and others from more than fifty years ago.⁴ These forces include the rise of an ideology favoring community-based solutions for social problems over institutionally based ones; the resulting creation of community-based mental health services that allow people to be treated and supported outside of large institutions; legal reforms ensuring due-process rights for people involuntarily hospitalized or at risk for such hospitalization; and the evolution of public insurance programs—specifically, Medicare and Medicaid—which reimbursed care in alternative settings such as nursing homes and encouraged use of other settings (principally local community hospitals) for acute inpatient treatment.⁵ These factors, combined with other social welfare, political, medical, and legal reforms and innovations, resulted in dramatic reductions in the use of U.S. state hospitals during the last half of the twentieth century.⁶

The second principle is that the state hospital's primary function within the continuum of care and treatment for mental illness appears to be the management of people deemed inappropriate—for behavioral, financial, or other reasons—for placement in alternative mental health settings. As the studies cited in our introduction suggest, state hospitals' clientele has changed over time as other service system components have evolved, but they retain their mission of serving these clients and providing functions that other providers cannot or will not provide.

■ **Treatment and reimbursement in state versus general hospitals.** Within this continuum, state hospitals share the acute inpatient treatment function mainly with general hospital psychiatric units and, to a lesser extent, private psychiatric specialty hospitals. Many general hospitals operate locked units, and, like state hospitals, many accept involuntary patients. Acute treatment in general hospital units is reimbursable through a variety of private and public insurers, including Medicaid. Unlike general hospitals, state hospitals cannot receive Medicaid payments under the federal Institutions for Mental Disease (IMD) regulation, which prohibits Medicaid reimbursement for care provided in facilities with sixteen or more beds of which more than half are occupied by patients whose primary diagnosis is a psychiatric illness.

However, as relatively small units within larger medical facilities, general hospital psychiatric units have too few beds to accommodate patients needing extended treatment and, in any case, would typically be prevented from doing so by the managed care entities associated with their patients' insurance coverage. In

addition, many general hospitals have been reluctant to admit people who pose a serious risk of violence toward others, appear difficult to discharge, or display inappropriate sexual or other problematic behavior that would place other patients or staff at risk.⁷ State hospitals, on the other hand, have significant excess bed capacity as their populations continue to shrink and can thus be flexible as to the number of people they can accommodate. Also, because they typically maintain multiple units featuring varying levels of security, state hospitals can absorb a broader range of patients than private hospitals can.

■ **State hospitals' link with community-based services.** State hospitals also operate within service areas featuring varying levels and types of community-based services. These include residential programs, which can range from intensively staffed, highly restrictive group homes to programs in which people live independently or with their families, assisted by support from outreach workers and case managers. Many systems also feature day treatment, employment, and clubhouse programs as well as case management and other services designed to promote successful integration into the community for their clients. Systems vary widely, however, in the levels and types of services they maintain, and this variability affects the breadth of clientele they can support in the community. The state hospital's niche within its service area's continuum of care has thus been heavily influenced by the availability and scope of the community-based services operating in its area, as well as by the availability and accessibility of alternative inpatient providers.⁸

State Hospitals At The Turn Of The Twenty-First Century

As a result of service and policy interventions undertaken during the last half of the twentieth century, its final decade saw the U.S. state hospital population at a level just 5 percent of its 1955 peak.⁹ But this reduction had not resulted in the closure of large numbers of the hospitals themselves. Indeed, between 1972 and 1990, as the number of state and county psychiatric beds declined 70 percent, only fourteen of 277 state hospitals closed during the eighteen-year period. Thus, in the early 1990s, with large physical plants having to stay open to serve a dwindling number of patients, SMHA officials redoubled their closure efforts. Many diverted funds from hospital operations, investing them instead in expansion of community-based services. In 1981, for example, state hospitals received an average of 63 percent of SMHA budgets, but that share declined to 32 percent by 2004.¹⁰ In addition, more-aggressive efforts were undertaken to shift acute treatment to local general hospitals, where, as we noted earlier, Medicaid would pay for it.¹¹ As a result, forty-four, or nearly 17 percent, of the remaining 263 hospitals closed between 1990 and 2000.¹²

Where have these processes left us? In 2006 there were 228 state hospitals operating some 49,000 beds. In 2004, the nation's SMHAs collectively spent \$7.7 billion, or 28 percent of their total budgets, on state hospital operations. Many SMHAs continue to ponder the future of their state hospitals. In a 2003 survey of

state mental health commissioners, roughly half of respondents indicated that some kind of reorganization effort—closure, consolidation, or reconfiguration—was under consideration. The survey also found that as of 2003, the downsizing of the nation's state hospitals continued, but at a slower pace.¹³

Role Of The State Hospital In The Twenty-First Century

When President John F. Kennedy introduced the Community Mental Health Act of 1963—in his last address to Congress and his last piece of major legislation—he expressed the belief that eventually “all but a small portion” of those residing in large mental institutions could be served in the community.¹⁴ Consistent with this observation, we contend that the role of state hospitals has been one of managing populations deemed inappropriate for other settings. Based on that contention, one way to discern the state hospital's current role and function within the larger mental health system is to examine the characteristics of the patient populations it serves.

Several patient populations have gained prominence in recent years and likely will define the state hospital's mission for the foreseeable future. Among these are people with past criminal justice involvement, a growing “forensic” population, sexually dangerous persons, and, finally, what has been termed a “difficult-to-discharge” population. We describe each population briefly to provide a sense of the challenges they are likely to present in the coming years.

■ **People with criminal justice histories.** Since the 1970s, attention has been focused on the increasing rates of arrest and incarceration among people with mental illnesses who use state hospitals and other mental health services.¹⁵ This trend continues today. A recent Massachusetts study of the arrest patterns of the SMHA's clientele found that nearly 30 percent of a cohort of nearly 14,000 people experienced at least one arrest over a ten-year period. Many also experienced state hospital stays, and their previous charges, including drug and violent offenses, may have complicated their housing arrangements, employment, and other aspects of successful hospital discharge and community integration.¹⁶ Other studies have shown that arrests and state hospital admissions often coincide within a narrow time frame, which suggests that the challenge of managing hospital discharges for people with recent arrest histories may be quite common.¹⁷

■ **Forensic patients.** A more specific problem currently facing SMHAs derives from the legal status under which increasing numbers of people are now hospitalized. Most people enter the state hospital either voluntarily or through involuntary commitment. But so-called forensic patients are committed by the criminal courts because their competency to stand trial has been questioned, they have been found incompetent and have not regained competency, or they were adjudicated as not guilty by reason of insanity.

Since the increased admission rate of this patient group was first noted at the end of the 1970s, the percentage of people committed via this route, rather than

through civil commitment, has continued to grow.¹⁸ For example, between 1988 and 2008, the proportion of Vermont state hospital admissions accounted for by forensic patients increased 50 percent; in Massachusetts, 281 percent; in New York, 309 percent; and in Pennsylvania, 379 percent.¹⁹ This trend has major implications for state hospital operations and financing, in that the criminal courts, not SMHAs, control forensic patients' admissions and discharges, but SMHAs nonetheless are liable for the costs of their hospitalization.

■ **Sexually dangerous persons.** Correctional officials in many states have long recognized that even after completing lengthy prison sentences for sexual assault and related offenses, many people remain, in some cases by their own admission, "sexually dangerous." Since prison sentences cannot legally be extended based on perceived risk, officials in some states began to test the legality of committing such people to state hospitals under their civil commitment statutes. The legality of this process was challenged several times on various grounds, including whether sexual predators meet the standard of "dangerousness to others" by virtue of a "mental illness." A series of court cases culminated with the Supreme Court's ruling in *Kansas v. Hendricks* (117 S. Ct. 2072 1997), in which Justice Clarence Thomas, writing for the 5-4 majority, argued that states may define *mental illness* however they choose for purposes of civil commitment. Following this ruling, increasing numbers of states began screening inmates nearing completion of their sentences for possible civil commitment.²⁰ Some states maintain specialized forensic hospitals with appropriate levels of security and personnel to manage sexually dangerous persons, but others do not and are forced to use their "civil" state hospitals for this purpose—a function whose adoption many SMHA directors oppose.²¹

This trend presents new challenges for state hospitals; many sexually dangerous persons continue to meet criteria for dangerousness long after their initial commitment. Risk management protocol dictates that releasing them could pose a major threat to public safety. But even if a person has responded to treatment and is deemed unlikely to pose such a threat, community placement remains a daunting task, given prevailing public attitudes toward sex offenders. Many such people will thus experience lengthy stays, and, as new cases are admitted, sexually dangerous persons will become a part of new long-stay population—one that, again, will be the financial responsibility of the SMHA.

■ **Difficult-to-discharge patients.** Despite the widespread expansion of community services, many state hospitals retain a groups of difficult-to-discharge patients. A Massachusetts study, using detailed treatment team assessments of all patients residing in state hospitals for more than three years, identified many residents who presented one or more so-called barriers to discharge. These included combinations of complex medical conditions, "inappropriate behaviors"—some directly attributable to patients' psychiatric illnesses, others not—and potentially problematic sexual or other behaviors that would complicate their outplacement and could present risks to themselves or others.²² In addition to these barriers, a major chal-

lenge to discharge is some people's reluctance to leave the hospital and confront the challenges of life in a new setting. This reluctance has required development of new approaches to improving people's "readiness for change" in addition to addressing other identified barriers to discharge.²³

■ **Impact of economic climate.** The deteriorating economic climate of the early twenty-first century compounds some of these challenges. Efforts to outpace the difficult-to-discharge patients can go forward only if appropriate community services exist to accommodate them and hospital staff are available to prepare them for discharge. If new settings or intensified staffing levels are required for these efforts, this process will likely be put on hold, leaving these patients in the care of the state hospital, even if community placement would ultimately be less costly.

■ **Shifting demographics of state hospitals.** Not surprisingly, perhaps, the increased presence of people with histories of arrest or incarceration and those who have been eschewed by other settings has over time altered the demographics of state hospital populations. This change is reflected in data provided to us by the Organization of Northeast Mental Health Statistics Improvement Programs, which has monitored state hospital use since the 1980s. These data reveal the growth of two demographic populations that also predominate in the criminal justice environment: males and nonwhites. The proportion of males increased an average of 20 percent between 1991 and 2007 in the eleven states monitored for both years, while that of nonwhites increased an average of 48 percent between 1991 and 2007 in seven reporting states, ranging from 53 percent in Delaware to 158 percent in Massachusetts.

Recommendations For Today's State Hospitals

■ **Work with police and judiciary.** How might mental health officials confront the challenges posed by these population trends? In addressing the increased demand placed on hospitals by the criminal courts, SMHA officials might discuss with police and judges how state hospital resources might be used most appropriately. For example, questions have been raised regarding whether some forensic patients should be civilly committed rather than arrested and processed through the criminal courts and forensic system. This approach would allow hospital officials a greater say in discharge decisions.²⁴ The questions of whether mental health systems should bear the full burden imposed on them by the courts and whether the state hospital is, in any case, the optimal setting for some in this population are ones that could form the basis of such conversations.

■ **Consolidate hospital populations.** What should be done about the state hospitals themselves? The flattening of state hospital population trends argues against another round of aggressive closure efforts, although four states did close at least one facility between 2002 and 2006, and seven are planning to do so in the near future.²⁵ But more than fifty years of relative neglect has left many hospitals in a state of disrepair. The cost of refurbishing them would likely be considerable, however, and would compete with maintaining and expanding community-based services.

Perhaps a more viable alternative for systems operating multiple hospitals with small patient populations would be to consolidate those populations in a new facility. From the standpoint of SMHAs and their budgets, this approach presents a more attractive option than attempting to rehabilitate old hospitals. Although SMHA capital budgets are usually tapped to cover repairs to existing facilities, construction of new ones can be financed through bonds issued by the state. Under this approach, the SMHA would realize additional savings through closure of old facilities that may have become costly to operate. Difficult economic times for states might make garnering of legislative support for such a proposal difficult, unless a convincing argument can be made that a new hospital would save money in the long run.

■ **Relax IMD regulation.** Another potential lever for change, although highly controversial, would be to relax the federal IMD regulation to allow at least some reimbursement for treatment provided in state hospitals.²⁶ This rule, which was a strong motivator of the effort in the 1990s to shift acute treatment to general hospitals, would undoubtedly be met with strong opposition, given that Medicaid budgets are already strained at both the federal and state levels. However, a recently observed shortage in general hospital psychiatric beds in some states might provide at least an opening for discussion of this issue.²⁷

■ **Contract with private hospitals.** Some SMHAs might consider contracting with private psychiatric specialty hospitals to fill the role traditionally played by state hospitals. Many of these facilities feature units with gradations of security and are equipped to provide extended care. Administrators eager to close state hospitals and reduce state workforces might find such a "privatization" option attractive. Whether the management of these hospitals would also find such arrangements financially and administratively attractive is, of course, another matter. For such a transfer of function to work from an SMHA's perspective, the private hospital's commitment would need to be long term, especially if the substitution involved closure of a state facility. But such a commitment would likely depend on what future prospects and opportunities for inpatient psychiatric treatment and reimbursement were seen as likely to be available.²⁸

A Research Agenda On State Hospitals

Decision making around many of these issues would clearly benefit from more current empirical evidence and a rekindling of interest in state hospitals on the part of the mental health services research community. A host of new problems require attention. For example, evidence needs to be gathered with respect to best approaches for meeting the needs of difficult-to-discharge populations. Although these populations have been described in the literature, the methods used to achieve a rehabilitative model of care and, ultimately, to successfully discharge challenging patients are only beginning to emerge.²⁹ Also, there are currently few, if any, follow-up studies of outcomes for state hospital patients recently dis-

charged to newly developed community-based services or of how best to serve forensic patients and the courts that refer them.

DEVELOPING SPECIFIC POLICY RECOMMENDATIONS for the nation's state hospitals is difficult, for the very reasons we have emphasized throughout: their roles are fluid and greatly affected by both local and national trends, many beyond the control of their administrators and even the agencies that operate them. The perspective adopted in this paper suggests that although eliminating state hospitals may remain a goal, it is unlikely to be realized in the foreseeable future, given the enduring importance of the services they provide. Some may find this view pessimistic. But those who do should recognize that many of today's state hospitals have accomplished much. Most are now accredited. Some are affiliated with academic medical centers. The rights of patients treated in them are more comprehensively protected than they are in many general or private hospitals.³⁰ In short, they are not the "shame of the states" that were so harshly (but rightly) criticized sixty years ago.³¹ But regardless of the desire to close these facilities, SMHAs must ensure that they are adequately resourced and accessible to people whose needs cannot be met elsewhere.

NOTES

1. See J.P. Morrissey, H.H. Goldman, and L. Klerman, *The Enduring Asylum: Cycles of Institutional Reform at Worcester State Hospital* (New York: Grune and Stratton, 1980); R.G. Frank and S.A. Glied, *Better but Not Well: Mental Health Policy in the United States since 1950* (Baltimore: Johns Hopkins University Press, 2006); D. Mechanic, *Mental Health and Social Policy*, 5th ed. (Boston: Person Education, 2008); and C.A. Keisler and A.E. Sibulkin, *Mental Hospitalization: Myths and Facts about a National Crisis* (Newbury Park, N.J.: Sage, 1987).
2. P.J. Carling et al., "A State Mental Health System with No State Hospital: The Vermont Feasibility Study," *Hospital and Community Psychiatry* 38, no. 6 (1987): 617-624.
3. National Association of State Mental Health Program Directors Research Institute, "State Psychiatric Hospitals: 2006," State Profile Highlights no. 06-4, 21 November 2006, <http://www.nri-inc.org/projects/Profiles/highlight.htm> (accessed 9 February 2009).
4. Frank and Glied, *Better but Not Well*.
5. An important conceptualization of this process is in L.L. Bachrach, "A Conceptual Approach to Deinstitutionalization," *Hospital and Community Psychiatry* 29, no. 9 (1978): 573-578. See also A.B. Rothbard, E. Richman, and T.R. Hadley, "Unbundling of State Hospital Services in the Community: The Philadelphia State Hospital Story," *Administration and Policy in Mental Health* 24, no. 5 (1997): 391-398. An overview of the evolution of civil commitment law is available in P.S. Appelbaum, *Almost a Revolution: Mental Health Law and the Limits of Change* (New York: Oxford University Press, 1994). For a comparative analysis of service creation and financing, see W. Gronfein, "Incentives and Intentions in Mental Health Policy: A Comparison of the Medicaid and Community Mental Health Programs," *Journal of Health and Social Behavior* 26, no. 3 (1985): 192-206; and Mechanic, *Mental Health and Social Policy*.
6. Frank and Glied, *Better but Not Well*.
7. W.H. Fisher et al., "The Role of General Hospitals in the Privatization of Inpatient Treatment for Serious Mental Illness," *Hospital and Community Psychiatry* 43, no. 11 (1992): 1114-1119; R.A. Dorwart and S. Epstein, *Privatization of Mental Health Care: A Fragile Balance* (Westport, Conn.: Auburn House, 1993); and J.L. Geller, "Excluding Institutions for Mental Diseases from Federal Reimbursement for Services: Strategy or Tragedy?" *Psychiatric Services* 51, no. 11 (2000): 1397-1403.
8. W.H. Fisher et al., "Case Mix in the 'Downsizing' State Hospital," *Psychiatric Services* 47, no. 3 (1996): 255-262.

9. Frank and Glied, *Better but Not Well*, 55.
10. NASMHPD Research Institute, "Closing and Reorganizing State Psychiatric Hospitals: 2003," State Profile Highlights no. 04-13, March 2004, <http://www.nri-inc.org/projects/Profiles/highlight.htm> (accessed 9 February 2009). This observed reduction in state hospital funding likely does not reflect reductions in per patient funding. Indeed, given the necessary infrastructure remaining even after significant patient reductions—record rooms, heating and lighting, and so forth—the per patient cost likely increased.
11. A detailed account of this process as it unfolded in one state is provided in C.C. Upshur et al., "Closing State Mental Hospitals in Massachusetts: Policy, Process, and Impact," *International Journal of Law and Psychiatry* 20, no. 2 (1997): 199–217.
12. NASMHPD Research Institute, "State Psychiatric Hospitals: 2006."
13. NASMHPD Research Institute, "Closing and Reorganizing State Psychiatric Hospitals: 2003."
14. John F. Kennedy, Message from the President of the United States Relative to Mental Illness and Mental Retardation to the House of Representatives, 5 February 1963, reprinted in H.A. Foley and S.S. Sharfstein, *Madness and Government: Who Cares for the Mentally Ill?* (Washington: American Psychiatric Association Press, 1983), 163–177.
15. See, for example, H.J. Steadman, J.J. Cocozza, and M.E. Melick, "Explaining the Increased Arrest Rate among Mental Patients: The Changing Clientele of State Hospitals," *American Journal of Psychiatry* 135, no. 7 (1978): 816–820; and H.J. Steadman et al., "The Impact of State Mental Hospital Deinstitutionalization on U.S. Prison Populations, 1968–1978," *Journal of Criminal Law and Criminology* 75, no. 2 (1984): 474–490.
16. W.H. Fisher et al., "Patterns and Prevalence of Arrest in a Statewide Cohort of Mental Health Care Consumers," *Psychiatric Services* 57, no. 11 (2006): 1623–1628.
17. R. Rosenheck et al., "Bed Closures and Incarceration Rates among Users of Veterans Affairs Mental Health Services," *Psychiatric Services* 51, no. 10 (2000): 1282–1287.
18. J.L. Geller and E. Lister, "The Process of Criminal Commitment for Pretrial Psychiatric Examination: An Evaluation," *American Journal of Psychiatry* 135, no. 1 (1978): 53–60.
19. Data provided by the Northeast Mental Health Statistics Improvement Program.
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21. NASMHPD, "Position Statement on Laws Providing for the Civil Commitment of Sexually Violent Criminal Offenders," adopted 9 September 1997, http://www.nasmhpd.org/general_files/position_statement/sexpred.htm (accessed 9 February 2009).
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23. D.I. Meyerhoff, R. Smith, and J. Schleifer, "Academic-State Hospital Collaboration for a Rehabilitative Model of Care," *Psychiatric Services* 59, no. 12 (2008): 1474–1475.
24. K.L. Appelbaum et al., "Are Pretrial Commitments for Forensic Evaluation Used to Control Nuisance Behavior?" *Hospital and Community Psychiatry* 43, no. 6 (1992): 603–607; and K.L. Appelbaum and W.H. Fisher, "Judges' Assumptions about the Appropriateness of Civil and Forensic Commitment," *Psychiatric Services* 48, no. 5 (1997): 710–712.
25. NASMHPD Research Institute, "State Psychiatric Hospitals: 2006."
26. Geller, "Excluding Institutions for Mental Diseases from Federal Reimbursement."
27. NASMHPD Research Institute, "State Psychiatric Hospitals: 2003."
28. See discussions in Dorwart and Epstein, *Privatization of Mental Health Care*; and Fisher et al., "The Role of General Hospitals."
29. Fisher et al., "Long-Stay Patients"; and Meyerhoff et al., "Academic-State Hospital Collaboration."
30. J.L. Geller et al., "The Rights of State Hospital Patients: From State Hospitals to Their Alternatives," *Administration and Policy in Mental Health* 25, no. 4 (1998): 387–401.
31. A. Deutsch, *The Shame of the States* (New York: Harcourt Brace, 1948).